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CLINICAL LECTURE.

THE USE OF CREOLIN. TREATMENT OF OCCIPITO-POSTERIOR POSITIONS.¹

BY EDWARD P. DAVIS, M. D.,

VISITING OBSTETRICIAN TO THE PHILADELPHIA HOSPITAL, ETC.

Gentlemen: This morning I wish to call your attention for a portion of my hour to a new antiseptic agent which has been attracting the notice of the profession of late in Germany, and more recently in this country, and which we have introduced with satisfactory results into general use in the Maternity Wards of this Hospital. I refer to creolin.

This germicide is a proprietary product of the same order as carbolic acid. It is obtained by a dry distillation of the best

varieties of coal, and is an oily liquid of a strong tarry odor and a dark brown or black color. In the unadulterated form, it leaves a stain upon the hands when immersed in it. It is soluble in alcohol, ether and chloroform, but insoluble in water. When mixed with the latter, however, it forms a uniform emulsion, slightly alkaline in reaction, and this, through a series of bacteriological tests, has been proven to be possessed of strong antiseptic properties.

As you know, the employment of the antiseptic agents now in general use, namely, the bichloride of mercury and carbolic acid, is attended with several marked disadvantages. Quite a number of cases of severe and even fatal poisoning have been reported in medical literature from the use of both of these germicides as vaginal douches and for intra-uterine injections, while carbolic acid in improper dilution has repeatedly produced severe burns of the unfortunate patient. Such being the case, any germicide which possesses the antiseptic

¹ Delivered at the Philadelphia Hospital.

tic properties of these agents, and at the same time is free from their deleterious effects must of necessity commend itself to the profession, and rapidly grow into favor. Such a germicide we believe creolin to be. The observations of all of the investigators who have tested it in series of cases are unanimous in the assertion that it is a comparatively harmless product unattended with marked poisonous properties, and that when injected into the genital canal of the parturient woman it acts as a lubricant superior to vaseline or carbolyzed oil. It has also been found to be of considerable value as an hæmostatic.

The method of using creolin in labor is as follows: To increase its lubricant and cleansing properties, and in order that it may more thoroughly permeate the entire vaginal canal, the Germans have been in the habit of adding mollin, a fatty soap made at present exclusively in Germany, to make a two per cent. emulsion of the creolin. But as mollin is expensive in this country, and as we have found green soap to be equally valuable when so used, we have substituted it in the place of the other. The following is the formula of the emulsion as used in our wards:

R	Creolin	f 3 i
	Saponis viridis	ii
	Aque	f 3 iii
	Liq. Potassæ	f 3 iii
M.		

I will pass around these two bottles containing some of the preparation that you may observe its appearance and odor.

A bottle of this material is kept in the ward, and all that is necessary in order to make a two per cent. emulsion for immediate use, is to mix fifteen drachms in a pint of warm water: we then employ it as a vaginal douche before labor, injecting the emulsion by a glass syringe, fully distending the vagina before the fluid escapes. After labor we are accustomed to employ a two per cent. emulsion of creolin with water only as a vaginal douche, and if needed, as an intra-uterine injection. Such douches are given morning and night in all cases where stitches have been inserted, and, as I have said before, with excellent results. The bichloride of mercury is still used for disinfecting the hands and external parts of the patient.

While on the subject of the antiseptic treatment of labor, I wish to show you the form of antiseptic pad which we use now in

the Maternity Wards of this Hospital. In place of the napkins which were formerly used, and which were made to render service in a large number of cases, by thorough cleansing in the laundry, we employ now pads made of oakum covered with a little ordinary cotton batting (not absorbent cotton), the whole being enclosed in a piece of common cheese-cloth. These are soaked in a solution of bichloride, 1 to 2,000, and then dried ready for use. They should be removed when soiled, and burned, in this way avoiding a second using. It has been found that on an average six of these will be required on the first day, and after that four a day. The cost is but \$1.90 per one hundred and fifty pads, or one and one-quarter cents per pad, so you will see that the expense is reduced to the minimum.

I will now give you the history of a case of occipito-posterior position which was recently delivered in our Wards, and which is especially interesting and instructive.

M. O'B., æt. 32. Primipara. The patient's mental condition was such that an accurate history of her condition prior to admission could not be obtained. She said that her limbs were at one time greatly cedematous, but an examination of her urine was negative in its results, no albumin or casts being present. Labor pains began at twelve o'clock midnight of Saturday, September 14. At six in the morning of the fifteenth she was sent to the Maternity Wards. The os then barely admitted the examining finger, and the labor pains may be said to have scarcely begun. During the whole of Sunday she complained of pain, but no progress was made. That night to lessen her pain one grain of the extract of opium was administered by the rectum, pains continued all night and the next day, and by six o'clock Monday evening the os had reached the size of a dollar, and dilatation was progressing. By eleven o'clock dilatation was complete. The diagnosis of the position was now made, confirming that obtained by an external examination and auscultation, namely, right occipito-posterior. About two o'clock in the morning of Tuesday, the occiput seemed to lie almost directly toward the sacrum. At three-thirty o'clock the head was on the perineum in the right occipito-posterior position, and remained so for two hours, save that a partial rotation occurred, the head afterwards falling back, however. The uterus now became tonically contracted,

and the contraction ring could be felt plainly through the abdominal walls; foetal heart sounds became rapid and weak. At seven-thirty o'clock, after the patient had been catheterized, and a creolin douche had been given, ether was administered and Simpson's forceps were applied to the head in the pelvic axis and traction made. After a few moments' firm traction the head advanced. The uterus now seemed to be relieved of some of its spastic condition, and during the last traction contracted strongly, delivering the head. The vagino-rectal septum was lacerated through a length of from one and a half to two inches. As soon as the placenta had been expressed, stitches were inserted as follows: A continuous catgut suture was first applied to the rectal side from the apex of the tear downward; then several silk sutures were applied deeply in the vaginal side, and lastly the perineum was closed with deep silk sutures. The vagina and rectum were then washed out with a two per cent. creolin emulsion, and a pad placed between the knees, which were bound together until the ether narcosis had passed off. The patient was placed upon a liquid diet, and her urine drawn by the catheter every eight hours. Recovery from the etherization was prompt. The patient's condition is now very fair. The uterus is firmly contracted, but the external surface seems to bear two small fibroid tumors, which, indeed, had been felt before labor had commenced. Her temperature after labor was 100° , pulse 136, respiration 28. The temperature began to fall at once, and by evening of the next day was almost normal. The lochia have been normal in appearance and amount.

The child, which presented the characteristic appearance of a child delivered in occipito-posterior position—and, gentlemen, permit me to say there is no more sorry appearance presented, than by a child so delivered—breathed feebly immediately on delivery, but after receiving a hot bath, its respirations became stronger, and it has done well since. It was covered with meconium when born, a sign that it had undergone dangerous pressure during birth. It is now somewhat jaundiced, and has presented a most obstinate case of constipation, having had but one spontaneous evacuation of the bowels since delivery.

In closing my lecture this morning I will do so by giving to you some statistics of cases of occipito-posterior position,

published recently by a French writer (Bataillard, in *Annales de Gynécologie et d'Obstétrique*). He believes that clinical observations of occipito-posterior positions show that most of these cases terminate as occipito-anterior, namely 353 out of 400; that when the fetus weighs five or six pounds, in primiparae the labors are two hours longer in the occipito-posterior position than in the occipito-anterior, and that when it weighs from six to seven pounds, labor is three and one-half hours longer in the posterior than in the anterior position. In multiparae the duration of labor is about the same, but when the child weighs about seven pounds there is very little difference between the duration of the labor in the two positions. Out of the five hundred cases of occipito-posterior positions, there were but two maternal deaths, one from eclampsia and one from sepsis, making the maternal mortality in occipito-posterior cases .5 per cent., while in 660 cases of occipito-anterior cases the mortality was .46 per cent. The fetal mortality in the occipito-anterior cases was .76 per cent., while in the occipito-posterior cases it was 2 per cent. It is very evident, therefore, that our greatest anxiety in these cases should be regarding the life of the child. If closed at once under antiseptic precautions lacerations of the perineum in these cases generally heal, and do not seriously complicate the mother's recovery.

—TO HANDLE SMALL THIN SECTIONS: A very convenient trowel for this purpose is made by inserting the head of a large needle in a penholder or other suitable handle; then filing the needle flat on two opposite sides, and breaking off the point. Such an instrument does not take up as much fluid with a small specimen as the ordinary trowel does. It also has other advantages over the customary methods of handling small thin sections of either animal or vegetable tissue.

—COVER GLASSES, as sold nowadays, are not quite clean. They should be washed in distilled water and kept in a wide-mouthed bottle filled with alcohol acidulated with hydrochloric acid. They are readily cleaned with tissue or Japanese napkin paper between the thumb and forefinger. The patent devices for cleaning cover glasses are only serviceable to make a show of those who use them.

COMMUNICATIONS.

REMARKS ON A CASE OF
OVIARTOTOMY.

BY R. STANSBURY SUTTON, M. D.,

SURGEON TO TERRACE BANK HOSPITAL FOR WOMEN.
ALLEGHENY, PA.

The case you have just seen operated upon was a specimen of those not infrequently met with, viz.: a large multilocular cyst, with a twisted pedicle and extensive adhesions. The patient's temperature has been above normal every day for probably three months; she has had repeated sweats and considerable pain of a colicky character. During the last twelve years, I have met with and operated on a number of cases like this one. The twisting of the pedicle, followed by adhesions of the sac to the surrounding viscera and abdominal wall, has not, in my experience, save in a solitary instance, added to the mortality.

In 1877 I saw a woman ten days after her confinement and diagnosticated the presence of an ovarian cyst with a twisted pedicle, and urged an immediate operation. She was the daughter of a doctor, who had no faith in the diagnosis, and absolutely no knowledge of abdominal surgery, and was far advanced in years. She was permitted to go on unoperated upon for ten days longer, during the last four or five of which she had a temperature of 104° and severe sweats, and showed great exhaustion. When it was evident that she would die, I was requested to operate upon her, and did so. The pedicle was twisted, the cyst was gangrenous, and filled with bloody fluid, and there were numerous recent and soft adhesions. In this way nature tried to save her, but failed. There was one peculiarity about this operation which I will venture to mention. It was this: after taking the cyst out of the abdomen and dropping the ligated pedicle, I poured in to the cavity of her abdomen several tin cups full of hot water, and sponged it out again before closing the wound. After the woman died, which she did within three or four days, I imagined that the washing out of her abdominal cavity with hot water might have had something to do with her death. Now, when it is the rule to wash out the abdominal cavity after abdominal section, we see how difficult a thing it is to always determine, in

a new procedure, whether we are right or wrong.

You will observe that to-day we gave chloroform. I was brought up immensely prejudiced in favor of ether, but its tendency to congest unhealthy kidneys, to irritate sensitive bronchial surfaces, to produce nausea and vomiting and thereby favor the formation of secondary stitch-hole abscesses, has shaken my faith in its applicability in abdominal surgery. My assistant, Dr. Williamson, who was educated in the University of Berlin, has as great an antipathy to ether as I used to have to chloroform, consequently we have about ceased to use ether, using chloroform instead. Before operation this woman was given a bath, and her bowels were cleared out by means of a purgative given thirty-six hours before the time of the operation. For twenty-four hours before the operation she was fed on Bovinine and Beef Peptonoids; beyond this she had no preparatory treatment. Occasionally I quininize patients prior to operation.

You observe that no medicated liquids have been used during the operation; that the sponge water, and that used over the instruments, as well as the water in the irrigating reservoir, was simple clean, well-boiled water. You probably observed that I used sponges very little. This tube on the end of the hose washes out the abdominal cavity rapidly and effectually, leaving nothing to be removed by the sponge excepting a little water.

All raw points, you will remember, were touched with the Paquelin cautery. A drainage-tube was not put in, as there was no necessity for it, and the wound was closed with silkworm gut sutures, three or four to the inch. You will also observe that I have operated with but one assistant, my head nurse giving the anæsthetic, and two nurses waiting upon me. The nurse giving the anæsthetic has been at my side during operations for six years, and she and I have done an ovariectomy alone. I dislike a multiplicity of assistants; students of medicine are never admitted to my operations, and rarely more than two or three physicians. It is more than two and a half years since I have had a death from ovariectomy or oöphorectomy, and in my last forty-four ovariectomies and oöphorectomies the temperature has not, during the first week after operation, risen above 101° and in many of them did not reach 100° .

This is my argument to-day for disclaim-

ing all faith in the introduction of solutions of carbolic acid and bichloride of mercury into abdominal surgery. I would not have you believe that I use no chemicals in connection with these operations, because I and my assistant and nurses do use, for the proper cleansing of our hands, whatever chemicals are most suitable; but it may be laid down as a fixed fact that any irritating chemical introduced in solution into the cavity of the abdomen, will be eliminated through the kidneys, and imperil the life of the patient.

Time is an important factor in operations; in uncomplicated ovariectomies, I have frequently opened the abdomen, emptied and delivered the cyst, tied and burnt off the pedicle, in five minutes, spending afterwards fifteen minutes in cleaning out the abdominal cavity and closing the wound.

But a fair average time for an ovariectomy, unless it be a very complicated case, is thirty minutes.

Much has been said about the ligatures which we leave in the abdominal cavity. Thoroughly boiled silk is my choice, and on it alone I depend, using silkworm gut to close the abdominal wound.

Much has also been written about the surroundings of an abdominal operation. The weight of evidence is still in favor of the private hospital, although I believe that all abdominal operations are more safely done at present, both in and out of the private hospital, than they were five years ago. One reason of this, however, is that patients are accepting earlier interference. My experience may be unique, but I have never seen a woman die after the removal of an ovarian cyst unless she had been previously tapped.

ANTISEPSIS.

BY R. G. P. DIEFFENBACH, M. D.,
NEWARK, N. J.

Not many years ago antiseptics was an unknown part of medicine and surgery, and it has since its discovery entirely changed our methods, not only in surgery, gynecology, and obstetrics, but also in other therapeutic branches in the treatment and prevention of diseases, such as diphtheria, typhoid fever, and many others. Formerly a surgeon would not hesitate to operate for incarcerated hernia or in any other case of emergency immediately after treating a gangrenous or erysipelous subject; the only precaution

observed was to give his hands a good, and probably in many cases only a superficial, cleansing. The consequences, in the form of erysipelas, gangrene, septicemia and other similar diseases did not fail to make their appearance.

We owe the first impetus, the first system of antiseptic treatment, to Prof. Lister, and during the past fifteen years it has been improved almost daily and is now indispensable to the success in surgery and diseases in general.

It would occupy too much time to undertake to give a history of the development and describe the numberless ways in which antiseptics is used, and I will only endeavor to give a description of this mode of treatment as it is applied at the present time principally in surgery.

Antiseptics may be divided into two parts: First, the prevention of infection, called "asepsis," and, Second, the treatment of already infected wounds or tissues, called "antiseptics." In order to prevent the promotion of contagious diseases, it is first of all necessary to remove the cause and to have at all times a good supply of fresh air. A number of disinfectants are in use at the present time; the most common are: chloride of lime, solution of carbolic acid or corrosive sublimate, sulphur vapor, etc., etc. In the treatment of fresh wounds, to prevent inflammation and suppuration, the greatest care should be exercised. Cleanliness is the first and foremost part of antiseptics. For this reason, it is necessary for the surgeon and his assistants and nurses, before treating a wound or before making a smaller or larger operation or coming in contact with any part or parts which might be infected, to resort to a thorough cleansing of the hands. Brushing the nails is especially necessary, and, if an operation is to be done, the arms also. For this purpose and for the washing of sponges, Prof. Kimmel recommends the German green soap, which is extensively used in diseases of the skin, on account of its solvent properties. Then a solution of carbolic acid (about 3 per cent.) or of corrosive sublimate (1 : 1,000) should be applied. Instruments, after a careful cleansing, are to be laid in a 3 per cent. solution of carbolic acid for half an hour before being used. The patient should, if practicable, receive a bath before the operation and a thorough cleansing of the parts to be operated upon, which should be shaved if necessary, and then a solution of corro-

sive sublimate should be applied. During the operation the wound should be irrigated from time to time with a solution of corrosive sublimate (1 : 1,000 or 2,000) or with a 2 per cent. solution of carbolic acid. If the operation is in the abdominal cavity or pleura, the wound should be only moistened with a solution of corrosive sublimate (1 : 2,000). For the mouth, rectum, or bladder, salicylic acid (1 : 1,000), or boracic acid (2 : 100) are used with success; and at the end of the operation the wound may be sprayed with iodoform ether, one part to ten.

Dr. Baumann recommends an antiseptic gauze prepared by sterilizing the same in steam, at a temperature of 100° Celsius, (212° F.) or more, after which it is quickly dried in the same temperature and at once impregnated with some antiseptic solution. Smaller wounds may be dressed without sterilized gauze. Towels, sponges, sheets, silk ligatures and sutures should also be sterilized.

Prof. Bergmann claims that next to antiseptic treatment the greatest care should be exercised in regard to the bleeding and oozing of wounds, and says neglect of this care is one of the principal causes for the promotion of decomposition and suppuration of tissues and prevention of healing by primary intention. The wound should not be closed until it is perfectly dry and the smallest vessels have been tied. Drainage should be used, if the wound is not perfectly aseptic. If a wound is already infected by previous suppuration it is best to loosely tampon it with iodoform gauze, cut into strips, and the ends should be allowed to hang out of the most dependent corner of the wound. Over this an antiseptic dressing is applied without any sutures. This tampon remains for two, or, if larger vessels are oozing, four or six days. If the discharge penetrates, the outer part of the dressing is removed. The tampon is removed by gently extracting it without opening the wound, and a proper suture, with or without drainage, may then be applied.

For the dry dressing, which is much in use at present, it is absolutely necessary to have a material which readily absorbs all secretions from the wound. Iodoform, or subnitrate of bismuth in powder, or corrosive sublimate, or iodoform gauze, etc., are applied directly on the wound, then follows the absorbing material (in large quantities) such as cotton, jute or wood wool.

That antiseptic treatment is indispensable

in gynecology and obstetrics is known to every practitioner. In the latter there must be absolute cleanliness of attendants as well as of the room and bed, and vaginal injections with a solution of corrosive sublimate (1 : 2,000) or of carbolic acid (1 per cent.) should be used before and after labor. The use of oakum or cotton or an antiseptic pad, for the reception of lochial discharges, which can be destroyed as soon as saturated, is advisable. Intra-uterine injections of corrosive sublimate should not be stronger than 1 : 4,000 on account of toxic effects often met with. Lubricants for the fingers of the examiner should also be antiseptic.

In gynecology the same scrupulous cleanliness is necessary for operator, assistants, nurses, and instruments, and the parts to be operated upon and those in the neighborhood should be thoroughly cleansed by repeated washings and injections. The wound should be occasionally irrigated during the operation, and especially while it is being closed with sutures; frequent irrigations after operations are also necessary. Many of the German operators employ during the operation constant irrigation with a hot antiseptic fluid, of a temperature of about 120° F. The benefits derived from these are that the flow of blood is lessened, while they keep the parts clean, remove all necessity for sponging, and thereby shorten the operation.

There is yet one part of antiseptics, the importance of which is often overlooked, and this is the method of antiseptics as applied to newborn infants. It should always be borne in mind, that the act of being born is a violent insult to the integuments, above all to the head. It is only necessary to remember the peculiar anatomy which characterizes the skin of the newborn—the weak and delicate derma and the large amount of capillary and lymphatic vessels with a corresponding free circulation—to show to what a large degree infants are liable to septic influences. To prevent this, the attendants during delivery should use the proper antiseptics as already described. The umbilicus should be washed with a 3 or 5 per cent. solution of boracic or salicylic acid, and wrapped up in absorbent cotton. The use of carbolic acid or corrosive sublimate for infants is contra-indicated. For the prevention of ophthalmia Credé's method is highly recommended. It consists of putting one drop of a 2 per cent. solution of nitrate of silver in each eye.

The mouth of the infant should be washed after, and the breast of the mother before, each nursing with a solution of boric acid, to prevent the development of fungi.

These are some of the uses and methods of antiseptics to which attention may be properly called in such space as can be spared to this paper.

TURPENTINE IN AFFECTIONS OF THE THROAT AND LUNGS.

BY ARTHUR E. SPOHN, M. D.,
CORPUS CHRISTI, TEXAS.

I have been using pure oil of turpentine in affections of the throat and lungs for some time, and find better, and more satisfactory results, than from any other remedy I ever tried. I use the ordinary hand atomizer, and throw a spray of the liquid into the throat every few minutes, or at longer intervals, according to the gravity of the case. The bulb of the instrument should be compressed as the act of inspiration commences, so as to insure application of the remedy to the whole surface, which can be done in cases of children very successfully. It is surprising how a diphtheritic membrane will melt away under an almost constant spray of pure oil of turpentine. I now use the turpentine spray whenever a child complains of sore throat of any kind.

In cases of tuberculosis of the lungs, bronchitis, and the later stages of pneumonia, I have found the turpentine inhalation very beneficial. I use an atomizer, or paper funnel, from which the turpentine may be inhaled at will. I hang around the bed, and in the room flannel cloths saturated with oil of turpentine, in all cases of catarrhal bronchitis—in fact, in all affections of the air passages; and my patients invariably express themselves as being very much relieved.

—VARIATIONS IN THE COMPOSITION OF MILK.—From the results of about 50,000 analyses made in the laboratory of the Danish Dairy Supply Company, it is found that the dry matter less fat is an almost constant value (8.7 to 8.8). The fluctuations in total solids depend almost entirely on variations of the fat. The evening milk contains more fat and more total solids than the morning milk. In October and November the milk is richer in fat and total solids than in other parts of the year.

CASE OF IDIOPATHIC TETANUS.¹

BY W. L. COPELAND, M. D.,
CHICAGO, ILL.

G. B., 19 years old, salesman, strong, muscular, of good family history, on July 4 and 7, lay around on the grass most of the day smoking cigarettes. On July 8 he noticed some stiffness of the jaw and experienced difficulty in eating his supper. On July 9 the stiffness of his jaw increased, and about noon he called on a physician, who ordered potassium bromide. July 10 the muscles of his neck were stiff and sore, July 11 he was worse, and complained of soreness in the pit of his stomach. Three compound cathartic pills were ordered, and hydrate of chloral in conjunction with the bromide and a little nitrate of potash, as the urine was somewhat scanty. At 3 A. M., July 12, being unable to get his attending physician, I was called in to relieve the pain complained of in the pit of the stomach, which was constant, but also aggravated by severe spasms every ten or fifteen minutes. I found his pulse 140, his temperature normal, his head drawn back against the back of the chair upon which he sat. His teeth could be separated about one-eighth of an inch; his eyes were fixed; he had difficulty in swallowing and was unable to raise himself. I ordered morphia sulphate one-eighth grain, atropia sulphate one-eightieth grain and tincture of hyosciamus ten minims every hour. At 9 A. M. he had obtained no relief, his pulse was 144, his temperature 100°. Three hypodermic injections of one-quarter grain of morphia sulphate at half-hour intervals gave partial relief. Drachm doses of whiskey every hour, with a liberal supply of egg and milk, was ordered and a mustard poultice to the whole length of the spine. At noon his pulse was 110, his temperature 100°, and he was feeling easy, with only occasional spasmodic contractions of the diaphragm. At 6 P. M. his pulse was 120, his temperature 102½°. He was quite easy and talkative and could open his mouth about one inch. I ordered two minims of the tincture of aconite every hour until the pulse and temperature were reduced. At 9 P. M. his pulse and temperature were the same. During the night he received three hypodermics of one-quarter grain of morphia,

¹ Read at the October meeting of the Chicago Pathological Society.

but he only obtained short snatches of sleep. He passed urine freely two or three times during the night. On July 13 he had taken about ten ounces of whiskey since 11 A. M. of the 12th; his pulse was 120, his temperature $101\frac{1}{4}^{\circ}$. His skin was moist; he vomited once in the afternoon after severe spasm, then all the muscles relaxed and he slept about an hour and a quarter. He bit his tongue during the vomiting. During the day he expectorated great quantities of viscid saliva. At 8.30 P. M. his skin was drenched with perspiration.

July 15, in the morning his pulse was 96, his temperature 100° . As his bowels had not been moved for four days, I ordered three cathartic pills to be given, and then to be followed in four or five hours with enema of half an ounce of glycerine. As these failed to act the attendants on their own responsibility repeated the glycerine enema three times, and, there still being no result, three enemata of soap-suds were given, none of which had any effect except to aggravate the distress in bowels. As I was not at home when sent for, another physician was called in and two large enemata with one-half ounce of turpentine and some starch were given, and were also retained. On my arrival, about half an hour after the last enema had been given, the patient was suffering greatly, so I administered chloroform sufficient to partially relax the spasm, and dilated the sphincter ani, and a deluge followed. The patient passed a good night, sleeping the greater part of the time, his bowels moving once during the night. On the morning of July 16 his pulse was 96 and his temperature $99\frac{3}{4}^{\circ}$. July 19 his pulse was 140, his temperature 103° . He was very restless, and had general stiffness of his muscles. Atropine, one one hundred and fiftieth grain, and morphine one-quarter grain was given hypodermically. July 20 his pulse was 120, his temperature $102\frac{1}{2}^{\circ}$. A fly-blister three inches by two inches was applied to his back over the spinal column. July 21 he was about the same. He was given an enema of soap-suds which moved his bowels, his bowels were also moved during the night. July 22 I met Dr. Brower in consultation at 8.30 A. M. The patient's pulse was 130, his temperature 105° . We ordered twenty grains of sulphate of quinia to reduce the temperature. At 12.30 P. M. his temperature was $100\frac{1}{4}^{\circ}$, his pulse 128. He had one and a half hours of sleep after the quinine I ordered, the quinine to be

repeated if the temperature increased. At 3 P. M. the quinine was repeated. At 6 P. M. his temperature was 103° . At midnight I was telephoned for, as the patient was wild and uncontrollable. I found him half off the bed, with hot skin, talking incessantly, and four persons trying to hold him in bed. I injected fifteen grains of antipyrine, but before I could remove the needle his struggles ceased and he dropped back dead. Rigor-mortis set in at once. About a pint of whiskey and from four to eight hypodermic injections of one-quarter grain of morphia were given daily throughout his sickness. His nourishment consisted of milk and egg-nog, and was taken freely until the last twenty-four hours.

GONORRHOEA AT FIVE YEARS OF AGE.

BY D. D. CUSTER, M. D.,
MANAYUNK, PA.

Recently a woman brought her five year old child into my office for treatment. She said that he was swollen and cried when he urinated. I examined his penis and found it very much enlarged, and to my astonishment discovered an intense gonorrhœal discharge, with a history of chordee and painful erections occurring at night. Upon questioning his mother I learned that the boy was sleeping with his sister, eighteen years old, who had leucorrhœa. The lad was extraordinarily developed and it seems to me that his disease must have been contracted by having intercourse with his sister. A lotion of lead water and laudanum was applied with absorbent cotton to the penis, and I ordered the organ to be frequently bathed in warm water. Alkalies were administered internally and other ordinary gonorrhœal remedies were used. In two weeks the aggravating symptoms subsided and the discharge ceased.

—DEAF ANIMALS.—Evidence exists that deaf mutes are not confined to the human race. In a farmer's herd for twelve years was a cow which never gave any sign of hearing, and the evident attempts of which at lowing had only resulted in a feeble guttural. Nothing abnormal could be discovered in the ears or the vocal organs.

SOCIETY REPORTS.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, October 3, 1889.

The President, ALFRED L. LOOMIS, M. D.,
in the Chair.

Dr. C. L. DANA read a paper on the

Pathological Anatomy of Chorea,

with report of a case. The paper dealt principally with the pathological anatomy of the nervous system. Before tabulating the history of cases reported by others, Dr. Dana described his own. It occurred in a Swiss, single, eighteen years old, who entered the hospital December, 1888. He had always been weakly and sickly as a child, but gave no rheumatic, venereal, nor alcoholic history. He began to have chorea at the age of six years. He had also had so-called epileptic attacks at intervals for several years. The fits began with a shrill cry. Dr. Dana regarded these as of a hysteroid character, and not true epilepsy. He had, however, once been trephined for supposed epilepsy.

As he lay in bed he was rather dull, although he answered questions correctly. His speech was slow and jerky, owing to the choreic movements. These were so severe in general that the patient could not feed nor wait on himself. There was no heart murmur, and the thoracic and abdominal viscera seemed normal. The patient improved markedly under treatment, including doses of chloral hydrate, until in January, 1889, when he contracted pneumonia and died. The autopsy revealed evidences of pneumonia, but normal heart, without the vegetations on the valves which were so common in epilepsy. The kidneys showed some chronic changes. The skull was unusually thick, being seven-eighths of an inch in a section of the occipital bone. The pia mater was somewhat thickened; the cortex of the brain appeared normal except for very superficial softening on the under surface of both temporal lobes. The cord appeared normal. Microscopical examination was made of sections of the motor convolutions, of the temporal and biparietal lobes, and of the corpora striata, thalamus, bulb, cord, and some of the nerves. In the brain there was a slight amount of lepto-meningitis; the gray matter was considerably in-

jected; the neuroglia was not much increased. The nerve fibres could be seen running up into the cortex, the transverse fibres of the cortex were also present. The chief changes were just beneath the cortex, the white matter here being honeycombed, the lesions being apparent in places to the naked eye. While there was no real arteritis or endarteritis, there were dilatations of the perivascular spaces, the vessel being distended by blood exudates. The process, while chronic, could not be looked upon as inflammatory, but rather as flabbiness and loss of tone of the vessel walls. At the base and tip of the temporal lobes, however, there was brain softening, and the white matter beneath was excessively honeycombed, while there was evidently an increase of the neuroglia cells. The sections of the internal capsule and adjoining part of the thalamus showed the same honeycombed appearance from vascular dilatations. Indeed in the internal capsule there were more serious degenerations, the blood-vessels seeming to fall to pieces, they were so degenerated. There was apparently some increase of connective tissue in the pyramidal tracts. The pia mater of the cord was somewhat thickened; in the cord was some congestion, the congestion being most marked in the lateral columns. It showed none of the honeycombed appearance seen in the brain and pons. In the lumbar cord a double canal was present. The anterior and posterior nerve roots showed no degenerated fibres.

There had been nearly two hundred reports of autopsies made on persons dying of chorea. He had been able to find only thirty-nine cases, however, in which a satisfactory report of the condition of the nervous system had been made; in some respects these were incomplete. They had shown that in death from chorea there were congestions, extravasations, emboli, and softening in the nerve centres; there was also much uniformity of heart lesions. It was however, only by a very minute and critical microscopical examination that much light had been thrown on the subject. Twenty-five of the thirty-nine cases were of the acute chorea of the Sydenham type, uncomplicated with insanity or other serious disorder. In only one case had no changes been found in the nervous system, and in this one Dr. Dana was disposed to think some lesions must have been overlooked. In the cases of acute chorea with insanity there was intense

cerebral hyperemia and thrombosis, with minute hemorrhages, much as in the uncomplicated cases. In chronic chorea, of which five autopsies had been made after a duration of the disease from four to twelve years, there was dilatation and thickening of the arterioles, with necrotic tendencies, spots of sclerosis, fungous growths along the vessels in one case; the cord somewhat similarly involved though to a less extent.

A study of the cases led to the belief, he said, that we were not very far from obtaining an anatomical basis for chorea. In the acute types there was hyperemia of the brain and of parts of the cord; in the brain it was not meningeal, but affected the deeper parts. It was more than an ordinary congestion. The arterial walls were paralyzed, dilated, badly nourished, and an exudation took place, the lymph spaces became distended and eroded. Sometimes spots of thrombosis and of softening of the vascular walls gave way, and there were small hemorrhages. On the other hand, the lymph spaces around the ganglion cells and neuroglia cells were not dilated, and there was no proliferation of connective tissue cells, no distinct sign of inflammation; the process was one of vasomotor paralysis. In the older cases the vascular changes were more marked.

In connection with the pathology, and in order to better understand it, the author spoke of the theories regarding the etiology of the disease. The principal ones which had been advanced were the humoral, the embolic, the subinflammatory, the functional or agnostic, and the infectious theories. It seemed to him that there were three things at least well determined in chorea, viz., the existence of an abnormal state of the blood, an intense cerebral hyperemia in certain parts, and a neurotic history.

The discussion was participated in by Drs. Gray, Starr, Putnam, Jacobi, Birdsall, the President, and the author. It turned largely on the theories of the causation of epilepsy, particularly that regarding infection, which seemed to Dr. Starr and the president as probable in some cases since in so many there was a history of rheumatism and cardiac complications which were believed to depend on microorganisms. Dr. Starr thought, however, that some cases at least must be of functional origin. Dr. Birdsall said the pathology given by Dr. Dana was very interesting, but it was a question whether the chorea was due to such lesions, or whether a functional disturbance

manifesting itself as chorea did not end in the lesions. He was disposed to entertain the latter view.

PERISCOPE.

Lumbar Hernia.

Dr. J. Hutchinson, Jr., contributes to the *Brit. Med. Journal*, July 13, 1889, an interesting paper on lumbar hernia, in which he says:

It will be admitted that any contribution to our knowledge of this comparatively rare form of hernia is worthy of record, since there are several points about it which are still doubtful. It is generally assumed that the small triangular space bounded by the external oblique and latissimus dorsi muscles, and the crest of the ilium (Petit's triangle), constitutes a relatively weak spot in the abdominal wall, that hernial protrusion may here occur, but that strangulation of the contained intestine is very unlikely to develop. Indeed, almost the only record of an operation for strangulated hernia in this region which we possess dates from as far back as 1738 (Ravaton's case), since in Mr. Edmund Owen's case the rupture was neither strangulated nor obstructed. To Mr. Owen, so far as I can ascertain, belongs the credit of having performed the first operation for radical cure of a lumbar hernia. There is singularly little evidence as to the anatomy of this form, and what there is hardly confirms the current view that the presence of Petit's triangle accounts for the development of the hernial protrusion. No specimen had hitherto been shown at the Pathological Society; and I believe the one which I was able to exhibit there a few weeks ago, through the kindness of Dr. Stephen Mackenzie, is the only dissection of a lumbar hernia in existence in London. It was obtained from an elderly and rather emaciated man, who died (from other causes) in the London Hospital; the hernia was about the size of one's fist, was situated in the left lumbar region lying over Petit's triangle, and extending nearly from the last rib to the iliac crest, and it had existed for some years. It could be made to markedly diminish on pressure, was resonant to percussion, and had an impulse when the patient coughed. Gurgling could be detected when reduction was made, the swelling returning when the pressure was taken off. It caused the patient no pain, and

hardly any inconvenience. I was naturally inclined to think that the hernia protruded through the orthodox triangle, but found, on dissection, that this was not the case, as the aperture, which would admit two fingers and was circular in shape, was really situated above and to the inner side of the triangle. The protrusion was, in fact, just outside the quadratus lumborum, through the transversalis aponeurosis and the latissimus dorsi, where the latter arises from the strong fascia covering the erector spinæ. Another interesting feature at the *post-mortem* examination was the absence of any peritoneal sac. The looseness of the attachments of the peritoneum in this region is well known, and is taken advantage of in certain operations, such as removing the kidney through a lateral incision. It was quite easy to make the peritoneum, by gentle pressure, protrude into the centre of the hernial tumor, and, as it was certain that it had habitually during life contained intestine, it is obvious that every time the latter was reduced the peritoneal sac must have returned with it into the abdominal cavity. Whether this feature has been present in other cases of lumbar hernia it is impossible to decide, but it is one rarely met with in connection with the more common varieties of rupture.

What part of the intestine was present during life in the hernia I was unable to decide; the descending colon lay just to the inner side of the aperture, but it is quite probable that some coils of small intestine really protruded. The fact that this can occur is proved by Ravaton's case, and that omentum may form part of the contents was also demonstrated in Baron Larrey's case. But it is no doubt true, as suggested by several writers on the subject, that the colon (ascending when the hernia is on the right side, descending when on the left) is the most usual part of the abdominal contents to protrude in this region.

With regard to the coverings of a lumbar hernia it might be expected that the outer part of the sac would contain some part of the internal oblique and the transversalis aponeurosis, for the muscular fibres of the latter cease externally to the usual site of the hernia. But such little evidence as we possess on the point does not confirm this view, for in the cases in which an incision has been made there is no mention of any muscular fibres being cut through. In my case the sac was really formed by a local hyperplasia of the subperitoneal fat which had

insinuated itself through the aponeurosis and muscles, and had thus come to form a tumor the size of an orange in the subcutaneous tissue. I have demonstrated the mode of development of fatty herniæ in the femoral, inguinal, and umbilical regions by a series of preparations shown at the Pathological Society. It is certain that this mode of origin of hernia (the protrusion of subperitoneal fat followed by the descent of a peritoneal sac, and sometimes of intestine) is more common than one would be led to suppose from the ordinary text-book accounts, and it was especially interesting to me to find the same thing occurring in the lumbar region. It is probable that the cases reported by Marmisse, Auzias-Turenne, Gosselin, and Marquez, were of the same nature. Out of the twenty-nine cases of which I have abbreviated the records, sixteen (over 50 per cent.) developed spontaneously, or were attributed to strain, and all of them were in adults or elderly subjects. Males and females appear to be equally liable to lumbar hernia; seven cases of this class (of apparently spontaneous origin) were on the left side, four on the right.

In six cases (about 20 per cent.) the hernia followed in the track of a previous abscess or sinus, four in males and two in females. An ingenious suggestion has been made that the path which the protrusion takes may be determined by the course of a nerve, especially perhaps the lowest posterior lumbar branch, and this may apply to the original abscess, which leads later on to the hernia.

In five cases the hernia was due to wound or other severe traumatism of the loin, and two were said to be congenital. About the origin of the last form of lumbar hernia we are absolutely in the dark, for there is nothing in the development of the abdominal wall that explains the formation of a gap in the lumbar region.

For practical purposes we may say that the spontaneous form of lumbar hernia is confined to the period of adult life or old age, whilst that due to abscess or traumatism may occur much earlier.

It is quite erroneous to attribute to M. Petit the first account of lumbar hernia. It was mentioned by Barbette so long ago as 1650, and several cases were reported before M. Petit's very imperfect record was published in 1783; nor, as already mentioned, is there strong evidence that in the majority of cases the

protrusion occurs through the triangle named after the French surgeon. Mr. Edmund Owen states that in the child on whom he successfully performed a radical cure the protrusion was at this site; but in the two other cases, in which one can feel certain on the point the triangle was not the seat of the hernia; in the former case it did not exist. As is well known, the latissimus dorsi and external oblique may be in close apposition at their attachments to the iliac crest; and Lesshaft, by examination of a considerable number of bodies, determined the fact that Petit's triangle was nearly always wanting in young children, and in about every fourth adult man. In grown-up women, however, it is practically constant. To those interested in the literature of lumbar hernia, Baron Larrey's and Dr. Braun's papers may be commended as giving the most complete account of the subject.

It only remains to say a few words as to diagnosis and treatment. With regard to the former, the mistake which has occurred most often has been to suppose that the hernia was a chronic abscess, and in Dolbeau's case the intestine was actually incised and a fecal fistula formed, which, however, ultimately healed. The absence of true fluctuation, the probable resonance, and the reducibility of the swelling, should serve to prevent such an unfortunate mistake. Other erroneous diagnoses that have been made are hernia of muscle, sarcoma, and hæmatoma: but it is unnecessary to do more than mention these. With regard to lumbar hernia, as is the case with most rare diseases, the knowledge of its possible occurrence is the first and the chief step towards a correct diagnosis. That in more than one case the swelling has been at first called a lipoma is not surprising, since it is probable that the hernia, in a fair proportion of cases, has actually consisted in a protrusion of the sub-peritoneal fat. At any rate, this view is supported by the example now brought forward.

With regard to treatment, the use of a well-made abdominal belt nearly always suffices, but one may safely conjecture that Mr. Owen's case will be followed by others in which a radical cure is effected by operation. It is a curious fact that Ravaton's case, reported more than one hundred years ago, remains the only one in which there is a clear history of operation for strangulation, though one or two others have been recorded in which this complication has occurred.

Massage of the Eye-Ball.

Mr. Simeon Snell, in an Address, published in the *British Medical Journal*, July 13, 1889, says:

A mode of treatment which has come much into vogue in both medical and surgical practice in recent years has also found its uses in ophthalmic cases; I refer to massage. It is true that there is not scope for the many refinements under various names with which massage has beset itself. The mode of employment as advocated on the Continent and in this country by myself is very simple. It consists in rubbing gently, in varying directions, to and fro, and in a more circular manner, the eyelids over the eye-ball. The friction may be concentrated chiefly on one spot or be more general, and the surfaces of the eyelids may be rubbed together. Usually a lubricant is used, and vaseline answers this purpose; but, especially in corneal and conjunctival affections, which are so often well treated by massage, the yellow oxide of mercury ointment, made with vaseline, is to be preferred, the value of the ointment and of the massage being made use of at the same time. Time compels me only to mention in the most general way the cases for which this method is applicable. Corneal and conjunctival affections, chiefly in chronic, but often in acute cases, derive great benefit from massage; generally they should be free from irritability. In the often obstinate cases of pericleritis it is frequently of great service.

Dr. Mules not long since recorded a case illustrating the value of massage in a recent instance of embolism of the central retinal artery; vision was recovered.

A class of cases has much interested me. I refer to traumatic cataracts, and I include among these soft cataracts which have been needled. I have no doubt that in many cases the process of absorption is decidedly promoted by massage. It should not be adopted until the eye is tolerably free from irritability. If the opening in the capsule is at all free, softened portion of lens can often be massaged out of the capsule into the anterior chamber, and any portions already there can be moved about in the aqueous. More recently I have made use of massage as a means of ripening immature cataract, especially in cases in which Foster's operation for maturation has not produced such a rapid development as could be wished. In others the anterior chamber

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may be tapped before commencing the massage. My experience is too limited at present to speak as to its value in these cases.

Some years since I met in the street an old infirm patient who had undergone successful cataract extraction in one eye. I asked when he was coming to have the other eye operated upon. He replied he was "rubbing it off." When I desired him to come and see me when he had rubbed it off, I little thought that I should be advocating massage as a means for promoting absorption, at all events, of traumatic cataracts, or, as my friend would have called it, "rubbing it off."

Nephrectomy of a Horseshoe Kidney.

Professor Socin, of Bâle, performed an exploratory operation last year on a woman, aged 47, who had been subject for thirty years to pains in the right hypochondrium, where a tumor had gradually formed. He aspirated, and found that the swelling contained urine; then he performed nephrotomy. Hydronephrosis was discovered during the operation. The urine passed by the urethra remained normal, but on and after the fourth day an abundance of turbid urine drained from the opening made in the kidney, and an examination led to the conclusion that parenchymatous nephritis and purulent pyelitis were present. On May 12 nephrectomy was attempted. After an abdominal incision and successful ligation of the structures in the hilum, it appeared that nothing was left to do besides setting free the lower part of the diseased kidney. On careful manipulation this extremity was found to be continuous with a bridge of renal tissue, which passed over the aorta and vena cava and joined the lower part of the left kidney. This bridge or isthmus was found to be but loosely connected with the great vessels. Dr. Socin divided it by means of the thermo-cautery, so that the right side of the horseshoe kidney came away. Five ligatures were applied to bleeding points on the raw surface left behind, which was then covered over by the capsule, the edges of the latter being united by sutures. An abdominal-lumbar drain was applied. The patient was in excellent health four months after the operation. In Bruner's (Heidelberg) similar case a horse-

shoe kidney was discovered at operation for the removal of a pyonephrosis. The isthmus adhered strongly to the vena cava; on attempting to separate them, profuse venous hemorrhage occurred, which was controlled with difficulty. The patient sank from exhaustion at the end of the operation.

A Drainage-Tube Passed Through the Rectum.

Dr. Mariani describes in the *Siglo Medico* a case where a rubber drainage-tube was passed into the abdominal wound after the removal of a large dermoid cyst which adhered to the parietes, the omentum, and the liver. The patient was 46 years old. The wound healed in a week, but the tube had been allowed to slip into the abdominal cavity. The patient complained of pain referred to the left anterior superior iliac spine. A week after the healing of the wound the tube was passed during defecation. It had probably caused inflammation of the adjacent large intestine, and passed through the softened walls of the gut. About twelve years ago an entire stump of an ovarian pedicle was passed at stool. The case occurred in Germany, and the patient recovered. The expelled body must have entered the intestinal canal in the same manner as in Dr. Mariani's case.

Indications for Operating on Disease of the Mastoid.

In the *New York Medical Journal*, May 25, 1889, Dr. Charles H. May gives an account of his experiences at the Aural Clinic of Prof. Hermann Schwartze, of Halle, Germany, who is a great authority on diseases of the mastoid. The indications for opening the mastoid, according to Schwartze, are:

1. Acute inflammation of the mastoid with retention of pus, if the application of cold by the ice-bag or coil and the performance of Wilde's incision have failed to cause the oedematous swelling, pain and fever to disappear. In children the palliative treatment may be tried a little longer, but in adults a delay until pyæmic or meningitic symptoms set in he considers decidedly. For, if doubt exists, it is better in his opinion to err by performing an operation which is now almost devoid of danger

to life. Even if no pus is found, the operation may be and often is curative in checking the further progress of the inflammation.

2. In chronic inflammation of the mastoid, where repeated attacks of swelling with consequent improvement have taken place, or where there has been the formation of abscess or fistulæ pointing or opening at or through the skin of the mastoid region, the neck, auditory canal or pharynx. The operation is recommended in these cases, even though there is no immediate danger of life, for in such cases surgical interference is less dangerous than the results of a continuation of the chronic inflammatory process.

3. In cases in which, although the mastoid appears healthy, externally, there is retained pus or cholesteatoma of the middle ear which cannot be evacuated by the natural channel, as soon as symptoms appear which indicate that complications dangerous to life are imminent.

4. In cases of long-continued pain in the mastoid region, although the bone is apparently healthy, when the pain is not controlled by other remedies. Here the chiseling of a funnel-shaped or boat-shaped piece of bone from the sclerosed cortical portion of the mastoid may effect a cure without the necessity of extending the opening into the antrum.

5. As a prophylactic measure against the fatal consequences which might ensue as a result of incurable purulent inflammation of the middle ear with fetid discharge, in cases in which there are no other symptoms of retention of pus in the middle ear, except an obstinate penetrating fetor of the pus, despite careful cleansing and disinfection through the auditory canal and the Eustachian tube. In these cases the antrum is opened and kept open for a time, in order to permit washing out of the middle ear from behind.

Large Families.

One of the New York papers having offered a prize to the Metropolitan mother who had successfully reared the largest number of boys and girls, quite a number of claimants with a dozen children appeared and a few with fourteen. But the prize was carried off by the mother of fifteen children, all living, the youngest being five years of age. The father of this interesting family was one of fifteen children, some of whom

have died, but the mother is one of fifteen, all of whom are living, some of them at advanced ages. The story developed by the prize offer is interesting, in view of the alleged deterioration of the human stock.—*Ledger*, Sept. 9, 1889.

Medical Aid Stations in Berlin.

The Berlin correspondent of the *Medical Age*, June 10, 1889, says that in Germany, especially in the metropolis, every city has provided for hundreds of medical aid stations—one in every four squares or so—where experienced medical services can be commanded in case of emergency. This institution is a blessing, especially at night, and is of equal service to the poor and the rich. The town pays for the medical officers, who are not at liberty to accept fees. The subject is of sufficient importance to engage the attention of the municipal guardians of American cities.

Congenital Chorea.

M. Michon showed at the March meeting of the Society of Medical Sciences in Lyons an infant suffering with congenital chorea. The infant, a male, was born at full term, and since birth has exhibited rhythmic convulsive movements of the muscles of the face and limbs. Its mother had suffered from an attack of "brain fever" at four years of age, and with regard to its grandmother, there was a history of convulsive attacks with contractions.—*Medical Press and Circular*, June 12, 1889.

Antipyrin, Antifebrin, and Phenacetin in Whooping-cough.

Dr. Leubuscher, of Jena, states in the *Centralblatt für klin. Medicin*, No. 7, 1889, that Sonnenberger, who was the first to recommend antipyrin as a specific in whooping-cough, has gone too far in his estimation of the remedy. When administered early, antipyrin is unquestionably capable of influencing the course of whooping-cough, both in its intensity and duration, so that in some cases the whole disease is passed with at most six or seven attacks of less intensity in the twenty-four hours, and ceases entirely after three or four weeks. On the other hand, however, Leubuscher was in no case either able to abort whoop-

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ing-cough with antipyrin, or, by administering it as a prophylactic to a child whose brothers and sisters were ill with the disease, to prevent an outbreak of it. In the height of the disease antipyrin is of as little service as the other remedies.

Leubuscher has obtained as favorable results from the cheaper antifebrin as from antipyrin; but on account of the danger of continuous administration of antifebrin he cannot unconditionally recommend it. The author found phenacetin completely inactive.—*Deutsche Medizinal-Zeitung*, July 1, 1889.

Mustard Plaster.

Never place a cold mustard plaster upon a patient. The shock is like a sudden plunge into cold water. Before you commence to mix the paste be sure you have all the necessary material at hand. First put a large plate where it can get warm, not hot. Then stir the mustard and flour thoroughly together before you add the water, which should be tepid, stir in enough water to make a paste about the consistency of French mustard. Place your cloth (an old handkerchief is best) on the warm plate, spreading the paste in the middle of it, leaving a margin wide enough to lap well over on all sides. Do not remove paste from the plate until ready to apply. Place a folded cloth between paste and patient's clothing.—*Trained Nurse*, July, 1889.

Chloroform in Diseases of the Lungs and Heart.

Prof. O. Rosenbach, of Breslau, states in the *Internat. klin. Rundschau*, No. 1, 1889, that a very large experience has persuaded him of the efficacy of inhalations of small quantities of chloroform in some cases of diseases of the lungs and heart. These are the cases in which one has to cut short relatively brief and frequent attacks. There is one advantage in inhalations of chloroform, that the physician can stop the inhalations at will and so have control of the dosage of the narcotic. They are especially active, he says, in the attacks of dyspnoea occurring in patients with heart disease and emphysema, in the frequent paroxysms of cough of phthisis, and often also in hiccup and in certain neuralgic disturbances of the heart.

In giving the inhalations, the author drops from seventy-five to ninety minims of chloroform upon some cotton in a funnel, and the patient is allowed to inhale the vapor slowly. The cone is not held too near, so as to allow an abundant supply of atmospheric air to enter the cone. The patients, he says, soon attain a certain degree of comfort or fall asleep, to awake in an hour strengthened. Even attacks of oedema of the lung can be aborted by it. Finally, the author recommends chloroform and the less irritating chloroform water as an analgesic and antiparasitic remedy for application to the parts of a larynx affected with tuberculosis.—*Deutsche Medizinal-Zeitung*, June 20, 1889.

Iodoform in Hemorrhage.

In the Bulgarian bi-weekly *Meditsinski Pregled*, Nos. 3 and 4, 1889, Dr. Mikhaloff, of Sophia, the editor, publishes a very interesting paper in which he highly recommends the internal administration of iodoform, in the dose of three-fourths of a grain five times daily, as an excellent remedy in hemoptysis, hematuria, menorrhagia, metrorrhagia, flooding after abortion, intestinal hemorrhage (including that of typhoid fever and tubercular ulceration of the bowels), bleeding from hemorrhoids, etc. He adduces a long series of instructive cases treated with the remedy, and adds that Dr. L. Serafimoff, of Sophia, also obtained most gratifying results from the drug in several cases of metrorrhagia and obstinate profuse bleeding from the nose. In conclusion, Dr. Mikhaloff suggests a trial of the remedy in dysentery, in which iodoform may prove beneficial, not only by virtue of its hemostatic power, but also as a disinfecting agent capable of checking any putrefactive processes in the intestinal contents.

Rapid Rotation of the Head in Occipito-Posterior Positions.

M. Budin calls attention to the fact that sometimes the fetal head, when in an occipito-posterior position, will perform rotation so rapidly that the occiput will come under the pubic symphysis while the limbs and body have not yet turned, so that the back of the head faces the anterior portion of the body of the fetus. In one case given, in which version was intended, the hand in-

roduced into the uterus to search for the mouth found it only by following the posterior plane of the body. M. Ribemont made sections of the frozen fetuses, which had first been put into a state of forced rotation as above described, and he found that the rotation took place not only in all the cervical column, but also in the dorsal region down to the seventh dorsal vertebra. On account of this known action, it was proposed to employ the forceps in occipitoposterior positions when the head arrived at the perineum and the rotation was not accomplished. Dr. Budin was lately able to make this new application of the forceps with complete success for the mother and child, and thus to give a practical demonstration that there may be a considerable degree of rotation of the fetal head, and that an accoucheur can bring about this movement in certain cases, without fear of a dislocation of the cervical column and death of the fetus.—*New York Medical Journal*, April 26, 1889.

Pathogeny and Metastasis of Eczema.

M. Gaucher states, in a communication to the *Bulletin Medical*, September 1, 1889, that it is often dangerous to cure eczema, especially in children. He thinks that the exaggerations of the anatomical school and of parasitic doctrines have caused the part played by humoral alterations in cutaneous affections to be completely forgotten. Something is known of chemical alterations of the blood and humors in diabetes, in gout, and in uremia; and in all these diseases metastases are observed which, according to the facts of contemporary science, can be called chemical metastases. Hence, in patients affected with eczema, he says, we may suspect the existence of toxic principles which are eliminated by the skin, which thus acts as a safety-valve. The toxic principles are the products of mal-assimilation. If the skin affection is suppressed, the toxic matter may accumulate in the internal organs and determine more or less rapid and more or less grave accidents, according to the seat of the metastasis. These accidents should be more frequent in children because of the greater activity of their nutrition, which leads to an easier displacement of toxic matter, and because of the delicacy of their organs; they should be graver in children because their resistance is less.

Gaucher gives nine observations, which appear to confirm his theory. He concludes that in old persons and in children much circumspection should be exercised in the treatment of eczema, especially if it is very extensive. The whole diseased area, he says, must not be treated at once, but it should be attacked in successive fractions. Too energetic topical applications should not be employed. It is necessary to proceed slowly, in order to habituate the organism, in some degree, to the suppression of the cutaneous emunctories, and to give time to the toxic principles to be eliminated little by little by the intestine or kidneys. In his opinion, it is even necessary to provoke this substitution of emunctories by the administration of purgatives, and of diuretics, of which, he says, milk is certainly best.

Death from Rattle-snake Bite.

It is very seldom that a death from rattle-snake bite is actually recorded; but the daily papers of October 1 report that a postal clerk on the route between Melbourne and Jupiter Inlet, Florida, died September 29 from the bite of a rattle-snake. About midnight of the day before he accidentally stepped on the snake as he was walking along the highway, and the reptile buried its fangs in one of his legs. He twisted a handkerchief about the wound and hurried to a physician. The wound was cupped and poulticed, and whisky administered freely, but the treatment proved unavailing.

Chloralamide, the New Hypnotic.

Dr. E. Peiper communicates to the *Deutsche med. Wochenschrift*, No. 32, 1889, an account of the experiences at Mosler's clinic with chloralamide. It was given in the form of a powder, in doses of from 15 to 45 grains, with 15 grains of elæosaccharum of fennel (a mixture of oil of fennel, one drop, and sugar, 15 grains); or in capsules, to be followed with a drink of milk, water, or coffee. It was frequently also given in a mixture:

R Chloralamide gr. xlv
Acidi hydrochlor. dil. qtt. v
Aque destil. f ʒ ii
Syr. rubi Idæi f ʒ iiss

M. Sig. To be taken in one dose.

Wiener med. Presse, August 25, 1889.

THE MEDICAL AND SURGICAL REPORTER.

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CHARLES W. DULLES, M.D.,

EDITOR AND PUBLISHER.

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The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

AMYLENE HYDRATE IN EPILEPSY.

New and effective remedies in the treatment of epilepsy are very much needed. From time to time many such have been suggested; but the hopes inspired by the assertions of their advocates have been dashed to the ground. Amylene hydrate is one of the most recent claimants for favor. In the *Neurologisches Centralblatt*, No. 15, Dr. H. A. Wildermuth, of Stuttgart, has an interesting communication giving the results obtained by him in sixty-six cases of epilepsy which were treated with amylene hydrate. From the *Wiener med. Presse*, August 25, 1889, we gather that the patients were about equally divided as regards sex, thirty being men and thirty-six women. The result is stated to have been favorable in the majority of the cases, and in some instances the disease seemed to be

absolutely aborted. As regards the quantity of the drug given, Wildermuth says that from thirty to forty-five minims were given at a dose, or from seventy-five to one hundred and twenty minims in the day. After a number of trials it was found most suitable to make a watery solution of the amylene hydrate, of the strength of one part in ten; of which solution from five to ten teaspoonfuls were given at a dose, in diluted wine or fruit juice. The character of the disease appears to have offered a severe test of the efficiency of the remedy; for with one exception the patients had been affected with epilepsy for years, and had been previously treated for a long time with bromides—the bromide of potash alone, or a mixture of the salts of bromine. In addition to the bromides, most of the patients had also received atropine, or pills of zinc and belladonna. The administration of the pills was discontinued immediately upon beginning the amylene treatment. The bromides, however, were not stopped at first, but were only lessened in quantity at very short intervals; and if, in spite of this, the favorable result apparently due to the amylene hydrate continued, the bromides were no longer given in any amount.

The results appear to be of special interest in cases in which there were a number of attacks at one time, which by other means we are often powerless to overcome. In such cases, Wildermuth states that one or two subcutaneous injections of the drug were found preferable to its administration in any other way. No bad secondary effects of any kind were observed in the employment of the drug in the manner described in the *status epilepticus*; but when it was used for a longer time in larger doses, some disagreeable symptoms occurred which deserve special mention. In the first rank is to be named deep persistent somnolency, which in certain cases set in, in a wholly unaccountable manner, even after small doses. This often ceased spontaneously after the patient had become accustomed

to the amylene, and did not necessitate a diminution of the daily dose. Administration of the remedy in more appropriate dose, and regular mid-day rest, were found of assistance in accustoming the patient to the action of the amylene. If this result was not secured, but the favorable action of the drug upon the epilepsy still made its repetition desirable, small doses of cocaine—one-third to five-sixths of a grain—given internally, were found to have a good effect in overcoming the somnolency. Rarer secondary effects than somnolency were digestive disturbances, constipation, and deficient appetite. These, he says, may also disappear spontaneously, or upon the administration of doses broken as much as possible. Wildermuth, however, declares that he has never observed continuous disturbance of the digestive functions.

An objection to the prolonged administration of the amylene hydrate—for months or years—is the fact that, in many cases, its anti-epileptic action ceases after six or eight weeks, and that further increase of the dose is inadvisable on account of the increase in the bad secondary symptoms already mentioned.

Wildermuth regards the employment of the drug as indicated: first, in epilepsy characterized by frequent paroxysms; second, whenever a patient shows the toxic effects of a bromine compound, and a temporary discontinuance of the remedy appears to be indicated; and finally, in nocturnal epilepsy, perhaps in this variety alternating with a bromide or, in recent cases, with bromide and atropine. According to his observations, the effect of the amylene in pure nocturnal epilepsy appears to be better than in the cases in which the attacks occur by day or by night in a less regular manner.

It is evident from Wildermuth's paper that he does not expect amylene hydrate to replace the bromides in the treatment of epilepsy, but rather that he regards it as preferable in certain varieties of the disease,

and as a substitute for them in the special conditions mentioned. The moderate tone he adopts in his praise the more inclines us to hope that other clinicians will find it as helpful as he has in the treatment of this distressing and obstinate disease.

ACID SUBLIMATE SOLUTION IN DIPHTHERIA.

Mercury is one of the oldest remedies in diphtheria. It was employed with confidence by physicians in the early part of this century, but fell into discredit at a time when it was much abused in almost all the diseases in which it was administered. In more recent years it has been recommended for internal use, especially by Dr. William Pepper and Dr. Abraham Jacobi. The latter regards it as most valuable in the laryngeal form of the disease. Mercury has also been employed in solution for its local effect; but whether used in the form of a spray, or applied directly by means of absorbent cotton and a probang, the results hitherto have not been encouraging. In the *Berliner klin. Wochenschrift*, August 26, 1889, Dr. Rennert, of Frankfort on the Main, recommends a slight modification of the method of applying the mercurial solution directly to the throat, which, he asserts, has been followed by excellent results in his own practice. The modification referred to consists in acidifying the sublimate solution with tartaric acid, as originally suggested by Laplace. The proportions of mercury and tartaric acid to the water are: bichloride of mercury, one part; tartaric acid, five parts; water, one thousand parts. In applying the solution, a wad of absorbent cotton moistened with it is held in a pair of forceps, and with this brush the false membrane adherent to the throat or tonsils is wiped off, from below upward. The author admits that it is by no means easy to clear the throat in this way; and perhaps to most persons the process would suggest scraping rather than wiping. If his statements are accepted, however, the results have been

exceedingly good: all of the sixty-two patients treated in this manner, during a period of fourteen months, recovered; fever disappeared in from one to five hours after removal of the membrane; and the only complications observed were, in one case each, inflammation of the middle ear, paralysis of the palate, strabismus, and very slight inflammation of a number of joints. It should be stated that when the membrane removed was deep seated, an ulcer was left; this it was found advisable to touch with the solution morning and evening until the fever subsided. No other local treatment was employed than the one described; but the author states that he willingly permitted the patients to suck oranges, in order that an acid reaction might be maintained in the pharynx.

The method described has much to recommend it on theoretical grounds: corrosive sublimate is probably a most efficient germicide and disinfectant, and the addition to it of an acid makes it more penetrating; and, therefore, its employment in the removal and destruction of the false membrane in diphtheria should prevent subsequent infection. But practically there are serious objections to its use in the way proposed. Most cases of diphtheria occur in young children, who do not co-operate with the physician and cannot be expected to. As a matter of fact, they usually make so great resistance to much milder local measures that the physician is obliged to desist from attempting them, lest the struggles of the little patient result in dangerous exhaustion. Moreover, the method is not applicable to cases in which the membrane is so extensive that it cannot all be removed. This Ren-
 ert himself admits. Any membrane left would serve as a fresh focus of infection. We may venture to conclude, therefore, that—if the experience of other observers confirms the results obtained by Dr. Ren-
 ert—the local use of an acid solution of corrosive sublimate will be found of service in cases of diphtheria in older children and

in adults, when the membrane is not too extensive to be removed entirely.

TREATMENT OF BURNS WITH IODOFORM GAUZE.

It is desirable in the treatment of burns to have a dressing that is dry; that will tend, at least, to prevent decomposition of the discharges; and that is anodyne. In extensive superficial burns a dressing of patent lint wet with carron-oil, followed, when the acute pain is over, by oxide of zinc ointment thickly spread on some soft material, gives excellent results. But the combined odors of the oil and of the discharges from the burn are offensive to most persons. At the meeting of the Congress for Dermatology and Syphilis, at Paris, August 5 to 9, 1889, Dr. Schiff, of Vienna, spoke of the treatment of burns with iodoform, which had been previously recommended by von Mosetig. Dr. Schiff asserts, according to the *Wiener med. Presse*, August 18, 1889, that iodoform lessens the violent pain felt in burns, and brings about a speedy recovery. According to the method he recommends, before the iodoform is applied, the blisters are removed and the burned surface is washed gently with cotton soaked in a one-half per cent. salt solution. Several layers of iodoform gauze are then laid upon the burn, a piece of gutta-percha is laid over them, then a layer of absorbent cotton is applied, and the dressing is held in place with a bandage. If the discharges from the burn soak through the dressing to the bandage, the latter and the cotton are changed; but the iodoform gauze is allowed to stay on until the end of the first or the beginning of the second week. Mosetig recommends that no water-proof material should be employed for the outer dressings, as they result in needless maceration of the granulations. When the burn is on the face, he recommends an ointment of iodoform, of a strength of one part to twenty, over which a mask of gutta-percha is placed. The dressing should be renewed daily.

Schiff states that he has treated in this way one hundred and nine cases of burn, some of them very severe, and has obtained a cure in most cases. If the gauze is properly applied, he says that no poisoning occurs even when the burn covers an extensive area. Hebra, of Vienna, was more reserved in his statement as to the good effect of iodoform; he said that he had seen good results from it at the beginning when the scabs had not separated; but after they had come away he thought the iodoform hindered the skinning over of the granulations. When this is the case, he asserted that resorcin in one or two per cent. solution, caused a rapid production of epithelium.

Those who have been successful in the treatment of burns by a certain method naturally will be very slow to change it for another; but it is always well to have more than one good method to which recourse may be had to meet the requirements of any case, or even to suit the preferences of the patient. In the present case, iodoform gauze will make an asptic dressing, and if it can, as Schiff and Mosetig say, be left on for a week or more, much discomfort and actual pain will be saved the patient. Moreover, this dressing is clean and is easily applied. We think it is worthy of a fair trial at the hands of surgeons and general practitioners in this country.

A MEDICAL PLAGIARIST.

The *New York Medical Journal*, October 12, 1889, contains an Editorial making appreciative reference to an article which was published in the *Pacific Medical Journal* for September, entitled "Gynaia—A Review." This article is exceedingly amusing, and would be very creditable to the supposed author, who modestly hides his personality under the *nom-de-plume* of "Figulus," were it not for the important fact that he stole it—almost word from word and point for point—from an Editorial in the *N. Y. Times*,

about ten years ago—July 8, 1878. It is likely that "Figulus" hoped this fact would not come to the notice of the readers of the *Pacific Medical Journal* on the Western coast of the United States, but he ran a little risk on the memories of its readers in the East.

We sincerely trust there is nothing more than a coincidence in the fact that the word "Figulus" means a potter, and that one of the collaborators, named on the title-page of the *Pacific Medical Journal* is Lewis Potter, A. M., M. D., Professor of the Theory and Practice of Medicine in Cooper Medical College, San Francisco.

TREATMENT OF BRIGHT'S DISEASE.

Among the various methods proposed for the treatment of Bright's disease, one of the most recent is that of a prolonged stay in a room with a very high temperature. This method, which was proposed by Dr. Luton, of Rheims, in August of this year, appears to be rational, and it certainly gave a good result in a case in which he watched its effects. It takes advantage of the intimate relation which exists between the skin and the kidneys in the function of excreting water. If patients with albuminuria, dropsy and a disposition to uremia are kept in a room with a temperature of 95° Fahr., a condition is provided appropriate to their sensitiveness to cold, while their defective excretion of urine is made up for by perspiration, the kidneys diminish their functional activity, and, under the influences of this relative rest, gradually return to their normal condition.

A small room, a quiet bed, a stove and a thermometer are all that is necessary. The degree of warmth must be such that the patient will be kept always on the border between perspiration and moisture of the skin. The principal part of the treatment is the constant staying in moderately warm and dry air. The method entails some discomforts in attendance upon the patient which, for the most part, can be obviated by having a window in the door.

Dr. Luton learned this method of treatment by accident. A woman who was affected with Bright's disease passed through different methods of treatment unsuccessfully, and then went to the Hôtel Dieu. Dr. Luton was always astonished when he entered her room to find how extraordinarily warm it was—at a temperature of 95° Fahr. While he himself felt very uncomfortable, the patient was very well and was scarcely noticed to sweat. There was no occasion to change the treatment; the patient recovered, the œdema subsided, and the albumin disappeared from her urine. After a month the temperature of the room was gradually lowered, and after a second month the woman left the room cured. Since more than a year the patient has returned to her usual manner of life and has enjoyed the most complete health.

This case is reported in the *Deutsche Medicinal-Zeitung*, May 23, 1889, and it would be interesting to know if another patient, subjected to such a temperature intentionally, would bear it as patiently, and secure as good results from it.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

INEBRIETY: ITS ETIOLOGY, PATHOLOGY, TREATMENT AND JURISPRUDENCE. By NORMAN KERR, M. D., F. L. S., President of the Society for the Study of Inebriety, etc. Second edition, 8vo, pp. xxxii, 471. London: H. K. Lewis, 1889.

Dr. Kerr makes a strong appeal that inebriety should be recognized and treated as a disease, not as a vice or a crime. This appeal is directed more to the sympathies of his readers than to their reason. In reading over the chapters treating of the predisposing and exciting causes of inebriety, we are led to think that, in the author's opinion, almost anything may serve as a cause. He cites the case of a clergyman: "Learned, studious, self-denying, he is an active and energetic worker in the service of his Master. . . . Under the influence of some sudden nervous shock, or, as I have also seen, through exhaustion of brain from excessive self and worry, his nervous system is shattered, he is completely crushed, and (it may be medically) takes an occasional alcoholic stimulant. He feels refreshed and rejuvenated for the renewed performance of the duties which lie so near his heart. . . . Insensibly he is drawn closer and closer within the fascinating, narrowing, physical embrace of alcohol"—and then, of

course, degradation is rapid. No one will deny that a clergyman—or any other man—who becomes a drunkard is diseased, and that he should receive medical treatment with a view to restore his wrecked physical condition and to strengthen his weakened will power and moral sense; but—apart from the palliating circumstances, which Dr. Kerr records with such a sympathetic touch, which explain and excuse but do not justify the act—the case is simply one in which a man yielded to temptation, ignored the consequences, and became a drunkard. He became a diseased man, but the act which made him such was not caused by disease. This distinction Dr. Kerr does not make.

In the treatment of the majority of cases, especially at the later stages, the author thinks there is nothing equal to a "lengthened abode" in a genuine or well-conducted home or retreat for inebriates. The book concludes with a good account of the laws affecting the inebriate.

The book is a special plea rather than a sound argument in favor of the author's thesis. It is interesting, however, and should be read by those who desire to hear all sides of the question.

BOOK ON THE PHYSICIAN HIMSELF AND THINGS THAT CONCERN HIS REPUTATION AND SUCCESS. By D. W. CATHELL, M. D. 8vo, pp. 298. Ninth edition, revised and enlarged. Philadelphia and London: F. A. Davis, 1889. Price, \$2.00.

The fact that this book has already reached a ninth edition clearly shows that physicians have felt the need of a book devoted to an explication of their relations to their patients, and to advice bearing upon the achievement of reputation and success. Dr. Cathell's book is now so well known that an extended review is unnecessary. Perhaps his readers will feel that his advice has in it too much of the wisdom of Solomon and too little of the spirit of St. Paul; but then those who feel so will be less likely to be harmed by it. The young man may perhaps put the book down with the feeling that, if the author is correct, there is more in show than in sound learning; whereas he should consider that learning may go unrecognized and unrewarded unless it is accompanied by pleasing, cordial manners and attention to all the little details which develop and maintain reputation and the success which follows it. The book is full of helpful hints, and is valuable if only for its suggestiveness.

IMMUNITY THROUGH LEUCOMAINES. By EUSEBIO GUELL BACIGALUPI. Translated from the second French edition by R. F. RAFAEL, M. D. 8vo, pp. x, 155. New York: J. H. Vail & Co., 1889.

The author believes that germs cause the infectious diseases—such as small-pox, fowl-cholera, cholera, anthrax, etc.; but he does not believe that the immunity which follows inoculation with the attenuated virus of the disease can be explained by the action of the microbes themselves. He has been led to this belief by a statement of Ferran's, that by habituating the nature of man to the poison produced by the microbe, he had rendered it refractory to the disease, just the same as immunity from the fatal effects of morphine is obtained by its frequent use. In this case it would not be the microbe, more or less attenuated in its disease-producing power, nor yet a similar disease, which produces immunity when inoculated; but it would be the poison generated by the vital activities of the microbe. A man supplied with abundance of food, but placed in a room hermetically sealed, will gradually

perish from the re-absorption of his own exhalations, which are poisonous to him. The same result will follow in the case of a fish in a glass-globe, supplied with water and open to the air, if the products of its life are left in the water. In other words, in all living beings the products of life are noxious to this same life. It follows, therefore, that microbes supplied with a limited amount of broth will perish from the gradual accumulation in it of their own noxious products—leucomaines; and that, if into this broth new microbes are introduced, they will die there, just as a man will die if he enters an apartment where others have already died after having absorbed all the elements of life existing therein and leaving behind the products of their own existence.

The author's theory as to the production of immunity, briefly stated, is that immunity in an infectious disease is secured by the inoculation of the leucomaine peculiar to the microbe causing the disease. This theory he supports by many ingenious arguments. The first part of the book explains the theory and the reasoning which led up to it; the second part is devoted to a demonstration of it; and the third part to an explanation of some of the phenomena of infectious diseases by the theory. The author attempts to explain how immunity may last for years, if it is due to the presence in the body of a leucomaine; but in this he cannot be said to have succeeded.

The book is an extremely interesting and valuable contribution to our knowledge of immunity. Its theory is not proved, but it deserves careful consideration; and it seems to us the best explanation of the subject yet offered. The work of the translator has been well done, but the appearance of the book is marred by a number of careless typographical errors.

DORANCE. By R. E. NELSON. 8vo, pp. 223. New York: John B. Alden, 1889. Price, 75 cents.

This book is not of the kind usually reviewed in the pages of the REPORTER, but it has been forwarded by one of our subscribers with a special request for notice. It appears that the author was not twenty years old when she wrote this book, and this adds interest to what is in itself a very interesting story with an admirable purpose, namely, to illustrate the injustice and wrong of the system of black slavery which used to be a blot to the civilization of this country. The story describes the vicissitudes of a white child that was kidnapped by a bereaved slave in revenge for her own loss, and describes the execution of a sort of poetic justice against this unfortunate child. The painful part of the story is made up at the end by a happy *dénouement*.

LITERARY NOTES.

—The first number of the *Lehigh Valley Medical Magazine* is an octavo of 46 pages and cover. It is to be published quarterly by the Lehigh Valley Medical Association, and is to contain the transactions and papers of the Association, and such other matters as may be found convenient and profitable. The price is to be \$1.00 a year. The first number is an admirable one, and its successors are likely to have the same character. It is not intended to compete with other medical magazines, but cannot fail to be of interest to the profession in the immediate neighborhood of the Lehigh Valley. The enterprise will have, we are sure, the best wishes of the already established medical publications.

CORRESPONDENCE.

Telephone Probe.

TO THE EDITOR.

Sir: If you can spare the space in your journal, I wish to discuss an invention called "the telephone probe," described in the REPORTER of Sept. 28. Will this "telephone probe" act as described? Two platina points project one-sixteenth of an inch through a canula; the platina wires are insulated to near the points; the opposite ends are connected to positive and negative pole of a battery; the circuit is to be completed by projecting the platina points against a bullet imbedded in the tissues of the human body.

This would no doubt work admirably, were the experiment tried outside of the body. But a line of contusion in the body, made by the passage of a metallic projectile will be filled with moisture, and the instant the probe point enters it, the moisture surrounding the platina points will complete the electric circuit as readily as if you had plunged the point into a tumbler of water.

Water is a fair conductor of electricity, and its conducting power is increased when it contains chloride of sodium in solution. The latter is present in the contents of sinuses through which we are most likely to wish to pass such a probe for diagnostic purposes. I therefore claim that such an invention, though in theory correct, is in practice unavailable.

Yours truly,

J. H. PAYNE, M. D.

Julietta, Ind.,

Oct. 3, 1889.

[Dr. Payne's criticism is incorrect. The whole basis of the invention, as properly described by Dr. Bashore, is "the greater conductivity of metal compared with the surrounding tissues of the body." There is some current all the time, of course, but the telephone or magnet only indicates the greater current produced in the circuit when it is closed by a bullet or other piece of metal. The small battery makes this possible.—Editor of the REPORTER.]

New Hypodermic Syringe.

TO THE EDITOR.

Sir: I notice in the REPORTER, Sept. 28, an article by John J. Thomas, M. D., of Youngstown, Ohio, in regard to a new form of hypodermic syringe. I think it has one fault, and that a very important one—the impossibility of total exclusion of air. The

section of the bulb itself will not always do it; neither will the pressure of the thumb and finger always graduate finely enough.

Yours truly,

W. H. LEWIS, M. D.

Biramwood, Wis.,

Oct. 6, 1889.

NOTES AND COMMENTS.

The Venom of Snakes.

The venom of the rattlesnake has been frequently made the subject of study, and, while its action as a poison has been generally conceded, some writers have endeavored to prove its efficacy as a drug. Surgeon L. A. Waddell, M. B., has recently been availing himself of his opportunities as a deputy sanitary commissioner in Bengal to determine a point about which it would seem that much uncertainty existed—the curious question of the effect of serpent venom on the serpents themselves. In a paper he has published he quotes the contradictory conclusions arrived at by previous experimenters, and endeavors to show that, from the accounts of the experiments, it by no means followed that death, when it occurred, was the result of auto-toxic action. Accordingly, he felt that the question was still open, and proceeded to some very interesting investigations, conducted under different conditions of temperature and season, verifying his results by control experiments upon other animals and by *post-mortem* examination of the snakes he employed. In every case the fresh venom was injected into the cobra with an ordinary hypodermic syringe; the serpents operated upon were all healthy, and had recently been caught; the snakes were kept under observation from nine to fifteen days subsequently, and were then killed. The experiments generally confirm and extend the principle formulated by Fontana in 1765, that the venom is neither a poison to the snake itself nor to those of its own species. This immunity is not to be explained upon the mere fact of the animal being cold-blooded, or upon the anatomical conformation of ophidians, since most, if not all, of the non-venomous snakes are susceptible to venom. Surgeon Waddell suggests that it may result from a toleration established through frequent imbibition of the venom in the modified or attenuated form which it assumes when mixed with salivary and gastric juices

and absorbed through the alimentary canal, and in support of this hypothesis he mentions the popular belief that certain snake-charmers, by a process of inoculation with venom, gain protection against the bite of a particular species of venomous snake. If this hypothesis can be verified by further experiments, it will go far towards affording indications for combating the action of the venom on man. The subject is of such importance, and the experiments detailed appear so conclusive, that we look forward with interest to the further prosecution of this inquiry.—*Lancet*, June 15, 1889.

Leprosy as Observed in England.

In the *British Medical Journal*, June 29, 1889, Dr. Jonathan Hutchinson says that it is generally believed that the profession divides itself into two camps, one asserting contagion and the other denying it. Now the truth is probably nearly this. No one denies the possibility of contagion in what may be called the abstract or non-practical sense, while all, or very nearly all, doubt whether contagion takes any important share in the spread of the disease. A recent experiment by inoculation appears to have proved that contagion can be artificially effected, but it does not prove, and is far from making probable, that accidental contagion is common or easy. With due care in the transplantation of a bit of living tissue, no doubt lupus might be transferred from one person to another and so also cancer, but neither of these diseases is contagious in a practical sense. In neither is there any necessity for isolation of the sufferer in order to give safety to others. Those who believe in the importance of the bacillus as being perhaps the *vera causa* of leprosy are bound also to believe that the disease may be contagious. The practical question is, however, under what conditions does it become so. On this point the testimony of modern observers in leprosy districts is very nearly unanimous. Neither in Norway, in Hindustan, or the West Indian Islands, do nurses or surgeons fear to come in contact with lepers from day to day for years together. So far as contagion is concerned, hundreds of surgeons, well acquainted with the dreadful nature of the disease, daily encounter the same risks that Father Damien did. They do so, however, in the firm conviction that the risk is nothing.

The sad illness and death of the heropriest has impressed the public with the belief that the disease is contagious, whereas it proves no such thing. The risks to which he exposed himself were far other than those of contagion—they were those of food as well. When I visited the leper establishments in Norway some years ago, I made diligent inquiry for instances of apparent contagion; I asked more especially whether strangers visiting Norway ever contracted it. Everywhere I met with an emphatic negative, but everywhere I was told of one well-known exception. This exception was a certain German officer who had come to live in Norway and had become a leper; but, added my informants, "he degraded himself and lived amongst the fishermen as they did, and he deserved to get it." The large leper establishments at Bergen and Molde were officered by healthy persons, and no one feared the disease. Recent microscopic discoveries have done something to explain the difficulty of contagion while at the same time confirming our belief in its possibility. They have shown that the microbe, which is no doubt the means of contagion, flourishes only in the true skin, and never invades the epidermis; and, further, that it is not present in the granulations of ulcerated parts. Thus it can probably be transferred only when special care is taken to secure the success of the experiment.

Our experience as to lepers in England is all in the strongest possible sense adverse to the belief in accidental contagion. We admit them into our hospitals, and observe no precautions; we allow them to mix freely with their relatives; in the case of children, to go to school; and, to give lastly the strongest possible proof, we permit leprous husbands to continue cohabitation with their unaffected wives, and no ill results ensue. I have with my present knowledge at least three married couples living under the conditions suggested, and in no instance has the wife suffered. Indeed, to sum up, there has not been in England, within my knowledge, a single instance of even suspected contagion. I have never myself seen a single patient in whom the disease had not been acquired during residence abroad.

The facts to which reference has been made being generally admitted, and once for all considered as beyond debate, the problem before us in our search for a cause becomes I think much narrowed. We feel sure that this cause is not contagion, we feel

sure that there is nothing in even the slightest degree associated with poverty, dirt, or hardship, we feel sure that nothing that we know of under the name of climate has anything to do with it. What then have we left us to inquire about? Little or nothing I would submit excepting the all-important question of food. Since it can begin without inheritance, is with the utmost difficulty contagious, since it effects those who live in hot climates, just as it does those who live in cold ones, pays no respect to wealth and station, to age or sex, but of those who live in the districts and conform to the local modes of life picks out one here and another there, we are I think driven to the conclusion that it must depend upon some very special kind of poison of rare occurrence taken in connection with food. Such an hypothesis would cover all the facts, and none other would. I do not believe that it is possible to suggest any other that would not be instantly confuted by the facts. If we conceive that the bacillus is received into the body in some article of food, and add to our hypothesis that it is probably by no means commonly present, we see at once how the occasional but very rare infection of those who visit leprous districts may be brought about, and how it is that of the natives themselves only a minority suffer. We see also how it is that recoveries now and then occur in those who leave the dangerous districts, whilst they are seldom or never witnessed in those who remain.

If the hypothesis here explained be the correct one, the kind of investigation now required is evident. We know enough as to the clinical history of leprosy and as to its pathological anatomy. We accept the bacillus as, in some sense at least, its cause, and we now have to seek the spores of the bacillus in the foods employed in the districts in which it is prevalent. This will doubtless be a difficult and laborious matter, but by judicious collection of facts I do not doubt that the scope of the inquiry may be narrowed to one of much smaller compass. We have to find some kind of food which is used in all the districts in which the disease prevails, and which is either wholly or partially disused in those where it is not known. We have to ask in what directions the progress of European civilization has modified the dietetic habits of the communities.

Dr. Hutchinson then cites a case of leprosy under his care which proves first, that leprosy

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may be acquired without inheritance, by residence in a district where it is endemic; secondly, that it is not necessary that there should be any exposure to hardship or poor food; thirdly, and most importantly, that the leprosy process may come entirely to an end during residence in England; fourthly, as regards the food hypothesis, we have the fact that the patient had eaten fish freely in Jamaica, almost every day, and that she abstained from it in England.

Diagnosis of Disease of the Pancreas.

From careful examination of a case which was under Gerhardt's care at the Berlin Charité, van Ackeren endeavors to assign a certain diagnostic importance to the presence of undecomposed carbo-hydrates in the urine of cases suffering from disease of the pancreas. The patient was a man, 49 years of age, admitted suffering from vomiting, constipation, and emaciation. To the right of the umbilicus there was palpable a painful irregular tumor which moved to the right when the stomach was full. The emaciation progressed, although the size of the tumor scarcely increased; œdema of the legs and ultimately ascites and hydrothorax set in, and he died five months after admission. At the necropsy there was found in the pyloric region an ulcerated carcinoma with secondary growths in the retro-peritoneal glands. Two such nodes were present in the pancreas—one in the tail and a larger one in the head of the gland. Two or three weeks before death, the urine, which had hitherto been normal, increased in quantity, notwithstanding the œdema, and the specific gravity went up to 1028 and 1030. Fehling's solution showed reduction only some time after heating, while the nitrate of bismuth solution turned black after some minutes' boiling. Polarized light was rotated to the right, and the fermentation test gave a positive result. The application of other tests showed these reactions as due to the presence of maltose and a closely allied carbohydrate. Indican was present in abundance, and there was no biliary pigment. The motions, although repeatedly examined, never showed any fat, but, on the other hand, there were numerous striped muscular fibres. As these symptoms were added to those of cancer of the stomach only two or three weeks before death, they probably coincided with the occurrence of secondary growths in the pancreas. The presence of striped muscular

fibres in the feces was of great importance, as they have been found in nearly all those cases, although here, as shown by the constipation which existed, they could not be looked upon as due to a rapid passage through the intestine. Both this symptom and the absence of indican from the urine have been attributed to the failure of trypsin. In a case recorded by Gerhardt, in which the enlarged head of the pancreas had led to intestinal obstruction, indican was absent, and that observer sought to invest it with some diagnostic significance; but it may be explained by albuminous matter not entering the intestine, as it has been shown that indican disappears entirely by the third day in cases of inanition. In this case it was present in abundance. With regard to the presence of fat in the feces, F. Müller has shown that when this occurs the case is always complicated by other conditions, especially jaundice. Here no biliary pigment appeared in the urine, nor was there any fat in the motions. According to von Mering, the pancreas possesses the most powerful diastatic ferment; and it is probable that it is the pancreatic secretion alone which converts the maltose, derived from the carbohydrates of the food, into grape sugar. As carbohydrates do not appear in the motions, the only symptom pointing to disturbance of this process is the excretion of sugar in the urine, and in this connection it is interesting to recall the fact, long ago observed by Frerichs, that in diabetes mellitus the pancreas is frequently found much atrophied.—*Practitioner*, June, 1889.

How Drunkards are Treated in Norway.

The London correspondent of the *American Practitioner and News* says that a well-known medical man, who has recently been in Norway, gives a glowing description of their manner of treating dipsomaniacs. An habitual drunkard in Sweden and Norway is treated as a criminal in this sense, that his inordinate love of strong drink renders him liable to imprisonment, and while in confinement it appears he is cured of his bad propensities on a plan which, though simple enough, is said to produce marvelous effects. From the day the confirmed drunkard is incarcerated, no nourishment is served to him or her but bread and wine. The bread, however, it should be said, cannot be eaten

apart from the wine, but is steeped in a bowl of it and left to soak thus an hour or more before the meal is served to the delinquent. The first day the habitual toper takes his food in this shape without the slightest repugnance; the second day he finds it less agreeable to his palate, and very quickly he evinces a positive aversion to it. Generally, the doctor states, eight or ten days of this regimen is more than sufficient to make a man loathe the very sight of wine, and even refuse the prison dish set before him. This manner of curing drunken habits is said to succeed almost without exception, and men or women who have undergone the treatment not only rarely return to their evil ways, but from sheer disgust they frequently become total abstainers afterward. —*Northwestern Lancet*, July 1, 1889.

Adonis Vernalis in Heart Disease.

L. Jumon states in *La France Médicale*, March 12, 1889, that *Adonis vernalis* has been employed in Russia from time immemorial as a domestic remedy in diseases of the heart, dropsy, etc. For some years it has been frequently the object of scientific investigation. Adonidin and picro-adonidin have been isolated from it; the latter has been employed with good result in cases of mitral and aortic insufficiency. It is given in chloroform water, in doses of one-sixty-fourth of a grain daily. In Italy another species of this plant, *Adonis aestivalis*, grows. Experiments instituted with it by Marfori and Borgiotti show an important improvement of the subjective symptoms of patients: cyanosis disappeared, diuresis occurred, oedema quickly subsided, digestion improved and the appetite returned. In some cases contraction of the volume of the heart and of the liver and dilatation of the pupil were observed. The frequency of the heart beat diminished with the increase of the diuresis. Special indications for adonis are: heart affections accompanied with pronounced symptoms of blood stasis; in these cases adonis brings about both a regular rhythm and also a diuresis lasting some time. The remedy is to be preferred to digitalis in that it can be employed without interruption until complete recovery occurs—for about fifteen to twenty consecutive days, so that diuresis becomes normal. The dose is from sixty to one hundred and twenty grains in the form

of an infusion.—*Deutsche Medicinal-Zeitung*, June 20, 1889.

Preparing and Mounting Sections of Brain.

The method which we have found to give the best results in preparing, staining, and mounting sections of brain and spinal cord is that of Sigismund Freund, of the General Hospital, at Vienna. We gave it in the *National Druggist* several years ago, but repeat it now in answer to a request from a correspondent. It is as follows: "The material is to be hardened first in a solution of bichromate of potash, or in Erlich's fluid (bichromate of potash, 5 parts; sulphate of copper, 1 part; distilled water, 200 parts), and afterward in alcohol. The sections are floated in distilled water, and washed thoroughly. A staining fluid is made by mixing equal parts of a 1-per-cent. solution of chloride of gold in distilled water and strong alcohol. The washed sections are put in this and allowed to remain from three to five hours. From this stain they are removed to a fixing solution consisting of caustic potash, 1 part; distilled water, 5 or 6 parts, and allowed to remain in it for two or three minutes. From this solution they are removed directly to a 10-per-cent. solution of iodide of potash, where they immediately assume a rose color, which, in the course of a few minutes, deepens into red. At this point, if the sections are from adult tissues, the preparatory stage ceases, and they may be transferred to alcohol and mounted in the usual way, but the brain and spinal cord of an embryo are far too delicate to be handled in this way, and the author treats them as follows: The preparations are brought upon a glass slide, spread by means of a camel's-hair brush, and gently dried by covering (without pressure) with a piece of filtering paper. If the sections be very thin and soft, even this must be avoided, for the fibres of the paper would leave traces on the surface of the sections, and render them unfit for the study of the nervous elements. Nothing else can be done but to apply a piece of filter paper to the edges of the stained preparation lying on the slide, and to draw off the alkaline fluid in this way. This is by far the most tedious stage of the process, yet it is always possible to avoid shrinking and to preserve the most sensitive preparations. The sections, nearly dried, are allowed to remain in water a few

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minutes and are then transferred to alcohol, and mounted in the usual manner in Canada balsam.—*National Druggist*, July 1, 1889.

American Academy of Medicine.

The American Academy of Medicine is endeavoring to make as complete a list as possible of the Alumni of Literary Colleges, in the United States and Canada, who have received the degree of M. D. All recipients of both degrees, literary and medical, are requested to forward their names, at once, to Dr. R. J. Dunglison, Secretary, 814 N. 16th street, Philadelphia, Pa.

Typhoid Bacilli in Drinking-Water.

The *Deutsche med. Wochenschrift*, July 4, 1889, states that in a certain part of a bathing village of Baden several cases of typhoid fever occurred in 1888. It was then learned that three of the persons who were taken sick in December drew their drinking-water from the same spring. In order to examine the water for bacteria, a flask holding about six fluid ounces provided with a ground-glass stopper, was rinsed out with a one per cent. solution of corrosive sublimate, and then sealed air tight with a rubber cap. The cap was removed at the spring, the water pumped for five minutes and every trace of corrosive sublimate removed from the flask and stopper. The bottle was then filled with the suspected spring-water and sealed with the stopper and rubber cap. Plate cultures made from the water showed after three days, on the average, 140,000 colonies for each cubic centimeter. A few colonies of typhoid bacilli developed on tin plates. These bacilli grew upon potatoes and showed the so-called polar granules. Hitherto typhoid bacilli in drinking-water have been certainly demonstrated only rarely.

A correspondent from Budapest writes to the *Wiener med. Presse*, August 18, 1889, that typhoid fever, which has been epidemic in different parts of the country, has broken out afresh, after a short pause, in the capital. Those regions, he says, are especially effected which are supplied with bad drinking-water, and whose newly completed streets and buildings have in them piles of filth and rubbish. One hundred and five cases of typhoid fever were brought to the notice of physicians in the first week in August.

NEWS.

—Dr. L. Brewer Hall has removed to 161 North 15th street, Philadelphia.

—Dr. Andrew Graydon has removed to 1338 Walnut street, Philadelphia.

—Dr. John B. Deaver has removed to 120 South 18th street, Philadelphia.

—Dr. W. B. Madden was killed at Johnstown, Pa., October 9. He was run over by a train while trying to cross the track.

—It is alleged that trichinæ have been discovered in hogs imported from the United States in San Louis Potosi, Mexico.

—The opening exercises of the Training School for Nurses of the Johns Hopkins Hospital, Baltimore, were held October 9, 1889.

—The remains of three more victims of the Johnstown flood were taken from Stony creek October 9. They could not be identified.

—Dr. F. L. Bowden, ex-Chairman of the Republican State Committee of Massachusetts, was stricken with paralysis at his home, in North Attleboro, on October 9.

—The President of the State Board of Health of Florida reports several cases of yellow fever at Key West. Precautions have been taken to prevent the spread of the disease.

—A Dr. Hugh M. Sutherland died from the effect of morphine poisoning at Bellevue Hospital, New York, October 10. He was but 29 years of age. His habits of dissipation, to which his suicide is chargeable, drove his wife to self-murder, her suicide occurring some time ago.

—Typhoid fever is epidemic at Aurora, W. Va., and it is said the country for miles around is infected. It is said that there is scarcely a family without one or more of its members prostrated with the disease, and in some localities there are scarcely enough well persons to nurse the sick.

—The first of the Philadelphia Polyclinic Evening Lectures, for the season of 1889 and 1890, was given October 8, 1889, by Dr. B. Alexander Randall. His subject was "The Anatomy of the Labyrinth of the Ear." The course is free to members of the profession and to medical students.

—Great excitement was caused in the beginning of October by the sending of poisoned candy to several clergymen in St.

John, N. B. The wife of one of the clergymen died after eating some of the candy, which contained strychnine. On investigation it is believed that the culprit is a man who had been in an Asylum but had been discharged as cured in May last.

—In Michigan, the reports to the State Board of Health for the week ending October 5, 1889, indicate that tonsillitis, typhomalarial fever, influenza, erysipelas, scarlet fever, puerperal fever and membranous croup had increased, and that cholera infantum, inflammation of the bowels, cerebro-spinal meningitis, inflammation of the brain and measles had decreased in area of prevalence.

—The charge of cruelty to an inmate against the Friends' Asylum, in Philadelphia, referred to in the *REPORTER*, October 5, have been investigated by the State Committee on Lunacy and it reports that "After taking the testimony of said complainants and of such witnesses as were on notice produced, we are unanimously of the opinion that the complaints are not well sustained, and that there has been no evidence produced which should impair the confidence of the public in this institution."

—The Bulletins heretofore issued by the Secretary of the State Board of Health of Michigan have mentioned the increase or decrease of diseases in which a difference of seven or more was shown between the percentage of reports stating the presence of the disease in the current week or month and in the preceding week or month, or in the corresponding month in previous years. Hereafter those diseases will be mentioned of which the comparison shows an increase or decrease of twenty-five per cent. from the preceding week or month, or from the normal, as the case may be.

—A preliminary injunction was granted October 8 against Dr. John L. Seitz restraining him from the practice of medicine in Harrisburg, Pa. The writ was asked for by Dr. Frost, who claimed he purchased Dr. Seitz's practice and was introduced by that gentleman among his friends as his successor. In the agreement Dr. Seitz was not to return to Harrisburg to practice his profession after he left for Columbus, Ohio. He returned, however, and resumed the practice of medicine in August. Argument will be heard October 14, when the Court will be asked to continue the preliminary injunction. Both are well-known physicians.

HUMOR.

DOCTORS WHO CAN SPEAK only one language seem to understand a great many different tongues.

HOLDING ON.—The story comes from the West of a miser who swallowed a five-dollar gold piece, but the stomach-pump could only bring up \$4.50.

QUEER PROOF-CORRECTING.—Some very amusing ways of marking mistakes in a proof are used by outside proof-readers, especially clergymen. A minister, in reading a proof of his sermon, discovered a "space" that was not shoved down. The space, of course, made a black mark, and instead of making an x on the margin, which is the regulation mark, he wrote the following: "To the compositor:—Please remove the superfluous mark before the word Paradise in this line." Another, wishing to have a letter turned rightside up, sent these instructions to the compositor: "Please insert an e that is not reversed." Another, finding a word that he thought spelled wrong, wrote the following on the margin of the proof-sheet: "The word with the line drawn through it don't look exactly right; consult your dictionary, and oblige." This way of marking proof is not relished by compositors, and does not tend to better their religious instructions.

PATRONIZING YOUNG DOCTOR.—There is a story going about so good that it ought to be made public, and so improbable that it must be true. A very eminent London surgeon—one of the lights of the profession—the other day observed a gentleman fall in the street. He went to his aid, and found he had broken his leg. It was only a simple fracture, but the man was badly hurt. The surgeon used his umbrella as a splint, and, with his own and borrowed handkerchiefs, bandaged the limb tightly, put the patient in a cab and drove to the nearest hospital. There they were received by a young surgeon or his locum tenens. "You've bandaged this very well," said the hospital surgeon. "You flatter me," said the great surgeon. "Not at all," said the other. "I suppose you've been attending an ambulance class. They say a little learning is a dangerous thing, but the little you've learnt you've put to good account. I can't give you your umbrella now, but if you leave your address it shall be sent home." "I had best give you my card," said the eminent surgeon. And he did so.